



HIV and AIDS: Considerations for Occupational Therapists



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Introduction

HIV and AIDS are prevalent infectious diseases. While a cure is not available for either, medical treatment and services can help people with HIV live long and meaningful lives. Therefore, it is very likely rehabilitation professionals will encounter patients of all ages with these conditions during the course of their work, regardless of whether or not they are the patient's chief medical concern. Many therapists may not be aware of the impact these conditions have on occupational performance, the therapy process, and overall function. This makes it crucial for therapists to provide inclusive, sensitive, and effective treatment to all those impacted by these conditions in an effort to improve their well-being and occupational engagement.

Section 1: History and Background

References: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) are two closely related chronic diseases that affect many people worldwide. HIV originates from a virus that weakens various parts of the immune system, and AIDS develops in the advanced stages due to significant immune system deterioration. While the body's defense system is largely affected by these conditions, HIV and AIDS can both influence the function of many other body systems as they become susceptible to infections. For this reason, it is important for those with HIV and AIDS to receive treatment that helps prevent complications and sustains overall quality-of-life.

Due to concentrated research efforts, healthcare professionals have learned quite a bit about HIV and AIDS over the years. However, clinicians should be aware of the path that HIV has taken since its first appearance, as this is an important part

of the disease's history. Early research suggests Human Immunodeficiency Virus (HIV) originated in West Africa in the 1930s in chimpanzees. It is unknown exactly how or when it first spread beyond that species, but the first documented case of HIV in humans was in the Democratic Republic of Congo in 1959. From there, the virus spread rapidly and developed a large presence in the United States by the 1980s. Due to the limited knowledge healthcare professionals had at the time and based on one of its methods of transmission, HIV was initially referred to as Gay-Related Immune Deficiency (GRID). Since that time, healthcare professionals have learned more about both conditions and understand how to effectively treat HIV and AIDS from a medical and therapeutic lens. This has resulted in expanded, more effective prevention efforts and evidence-based treatment to limit the spread of the virus.

Statistics reflect this, and show that new HIV infections and AIDS have both declined across the globe over the past two decades. However, these conditions are still very prevalent and considered one of the largest causes of death in the world. As of 2023, there were nearly 40 million people worldwide living with HIV. This virus is far more common in certain parts of the world – namely Africa, the Caribbean, central Asia, and Southern Europe – due to less advanced medical technology. Even so, HIV still affects those who live in places with up-to-date medical practices. For example, in the United States, statistics from 2022 show that 1.2 million people were living with HIV.

In order to effectively meet the needs of this population, therapists must be aware of each condition's stages, clinical presentations, medical treatments, and therapeutic potential.

This not only helps a provider's ability to educate patients, but also allows for appropriate treatment planning, goal setting, and intervention selection. These conditions are quite similar, though they differ in several important ways.

Human Immunodeficiency Virus

HIV is a retrovirus that primarily targets and weakens the CD4+ T cells, which are integral to the body's immune system. HIV also affects the microglia, macrophages, Langerhans cells, and dendritic cells, but to a much lesser extent. Being that it is a virus, someone can contract HIV several ways. HIV can be transmitted in any of the following ways:

- Through needle sharing, which may occur during intravenous drug use, as a result of a medical error leading to needle reuse between infected and uninfected patients, or from accidental needle sticks with objects that contain infected blood
- Passed from an infected mother to an uninfected child during pregnancy
- Passed from an infected mother to an uninfected child during childbirth
- Passed from an infected mother to an uninfected child during breastfeeding
- Through contaminated breastmilk
- Through contact with non-sterile medical equipment or devices that contain infected blood or bodily fluids
- Through oral, anal, or vaginal sexual intercourse with someone who has the virus (due to exposure to semen and vaginal secretions)
- Receiving a blood transfusion from an infected person

HIV symptoms vary depending on the progression of the condition. The first stage of HIV can last up to a few weeks. Some people do not experience symptoms during this acute stage, while others exhibit flu-like symptoms such as muscle aches, fatigue, sore throat, ulcers in the mouth, fever, skin rash, chills, night sweats, and enlarged lymph nodes. In the second stage of the condition – called

clinical latency or chronic HIV infection – someone with HIV may or may not experience symptoms due to their immune system impairments. Those who do have symptoms in stage two often display those similar to stage one in addition to shingles, pneumonia, and thrush (a yeast infection in the oral cavity). With proper treatment, people with a chronic HIV infection can remain in this stage for many years without major complications. People who receive ongoing treatment for a chronic HIV infection also cannot transmit the virus to their sexual partners. However, someone with an untreated chronic HIV infection may remain in the clinical latency phase for anywhere between 5 and 15 years. Regardless of whether or not they are undergoing treatment, individuals with a chronic HIV infection may transmit the virus if they have a detectable viral load. For this reason, close medical monitoring and blood testing are important parts of HIV management.

In terms of medical treatment for HIV, the gold-standard is ART, or Antiretroviral Therapy. ART is a cocktail of medications taken orally or via injection multiple times each day to reduce someone's viral load. There are various forms of ART, each of which is intended for different virus strains and people with comorbidities. While there is currently no cure for HIV, this combination medication stops the virus from multiplying, which slows the rate at which it affects the immune system. ART also makes it so the virus is undetectable in a person's blood. This not only stops the virus from being transmitted to someone else, but also assists with symptom management. In some cases, ART can slow or entirely halt the progression of HIV symptoms.

Acquired Immunodeficiency Syndrome

AIDS is considered the third stage of HIV, as this is what the virus progresses to if it is not treated. Many symptoms associated with AIDS are severe, but can be

attributed to other health concerns. For this reason, testing and close medical monitoring is crucial. AIDS is characterized by some of the following symptoms:

- Chronic diarrhea
- Extreme fatigue
- Rapid weight loss
- Difficulty swallowing
- Significant muscle weakness
- Skin bumps or rashes
- Pneumonia
- Recurring fever
- Severe night sweats
- Chronic swelling of lymph nodes in the neck, armpits, and/or groin
- Ulcers affecting the genitals, mouth, or anus
- Unresolving white spots on the tongue or in the oral cavity
- Memory loss
- Mood changes, such as anxiety and depressive symptoms
- Balance impairments
- Confusion
- Chronic headaches
- Vision changes

- Seizures

We mentioned earlier that there is no cure for HIV, and the same applies to AIDS. ART is also the recommended treatment for AIDS, and someone must remain on this medication for the rest of their life in order to see its effects.

HIV/AIDS Impact on Occupation

The aforementioned symptoms stand to impact nearly every occupational area for someone with HIV or AIDS. In particular, people with either of these conditions may experience some of the following functional and occupational concerns:

- Higher rates of disability, especially in older adults with HIV
- Decreased physical performance
- Impaired ability to establish or sustain interpersonal relationships
- Decreased health-related quality of life
- Difficulty with medication adherence, driving, and other IADLs due to neurocognitive deficits
 - One study found that people living with HIV who receive ART therapy demonstrate better cognitive performance than those who do not
- Slowed cognitive development in children and adolescents
 - One study found HIV particularly impacted processing speed, executive function, and working memory
- Variations in employment status

- A large review shows that employment in those with HIV is positively correlated with HIV testing, HIV medication adherence, and retention in HIV treatment

Section 1 Personal Reflection

What sort of patient education might an occupational therapist provide to someone with HIV? What about someone with AIDS?

Section 1 Key Words

Comorbidities - A term used to describe someone with more than one medical condition

Viral load - How much of a virus can be found in a certain quantity of fluid (mucus, blood, saliva, etc.)

Section 2: HIV Legislation in the United States

References: 12,13,14,15,16,17

An important aspect of HIV treatment that all healthcare providers should be aware of is HIV-related legislation. This legislation can impact the work therapists do and the course of treatment for some patients. However, HIV legislation may also be a component of disease education for patients who are newly diagnosed or are unfamiliar with the condition.

HIV criminalization laws differ from state to state, though all typically relate to lack of disclosure. This means someone failed to disclose their HIV+ status in one of two circumstances. Some states with HIV legislation consider non-disclosure to be

a felony charge while others classify it as a misdemeanor. Someone can be prosecuted under HIV criminalization laws for the following reasons:

1. Donating plasma, semen, internal organs, human tissue(s), skin, or blood while having an HIV+ status
2. Failing to disclose their HIV+ status to a past or present sexual partner
 - a. Most states fail to include specific verbiage that clarifies what constitutes an HIV-transmissible sexual activity.
 - b. The HIV+ individual may still be prosecuted even if: (1) their partner does not acquire HIV as a result of their sexual contact, (2) they use protective/preventive methods such as condoms, and (3) the person living with HIV did not mean their partner any harm.
 - c. This is inclusive of HIV+ individuals who are sex workers.

As of 2025, the following states have HIV criminalization laws in place:

- Delaware
- Florida
- Georgia
- Idaho
- Iowa
- Kentucky
- Maryland
- Michigan
- Mississippi

- Missouri
- Montana
- Nebraska
- North Carolina
- North Dakota
- Oklahoma
- Pennsylvania
- South Carolina
- Washington
- U.S. Virgin Islands

Some states have HIV criminalization laws in place along with one or two additional legal stipulations. The first of these is HIV-specific sentencing enhancements, which increase penalties for any sexual crimes that relate to someone's HIV status such as HIV exposure, sexual assault, and solicitation charges (even in the absence of sexual contact). The second of these is a requirement that someone be added to the sex offender registry after failure to inform a partner of their HIV status. States with these requirements include:

- Arkansas
- Indiana
- Louisiana
- Ohio
- South Dakota

- Tennessee
- Utah

There are also some states that do not currently have HIV criminalization laws in place; however, they do have the aforementioned HIV-specific sentencing enhancements in place for sex-related charges. These states include:

- Alaska
- California
- Colorado
- Guam
- Wisconsin

Some states have gray areas regarding HIV legislation. Specifically, there are some states that have legislation pertaining in a general sense to sexually transmitted infections (STIs) and communicable diseases. Since HIV technically falls under these categories, such laws *could* potentially be used to prosecute individuals with HIV who commit a non-disclosure crime. The following states have general STI/communicable disease laws, but no specific HIV legislation:

- Alabama
- Arizona
- Kansas
- Minnesota
- Nevada
- New York

- Oregon
- Rhode Island
- Vermont
- Virginia
- West Virginia

Lastly, some states have not enacted any legislation that singles out individuals with HIV nor do they have other forms of legislation that can be used to prosecute HIV+ individuals who commit sex-related crimes. These states and territories include:

- American Samoa
- Commonwealth of the Northern Mariana Islands
- Connecticut
- District of Columbia
- Hawaii
- Illinois
- Maine
- Massachusetts
- New Hampshire
- New Jersey
- New Mexico
- Puerto Rico

- Texas
- Wyoming

While there is less stigma associated with HIV and AIDS today, people living with these conditions are still subject to discrimination, prejudice, and mistreatment. These negative outcomes often come from interactions with others, such as lay persons who do not have the conditions, know nothing about it, and/or make incorrect assumptions about the conditions. People with HIV and AIDS also face discrimination in the form of societal barriers, and some view these criminalization laws as one such example. HIV criminalization laws have come under criticism for what many believe targets HIV-positive individuals who engage in specific activities without disclosing their HIV status. Many times, these activities refer to sexual intercourse, yet legislation is also known to inaccurately include activities that are not proven to transmit the virus. This indicates the continued presence of misconceptions and bias surrounding HIV and AIDS education.

Legislation changes often, so it is important to continually stay updated on amendments or other adjustments that impact the above laws and associated HIV programming. Specifically, in early 2025, the U.S. Secretary of State gave the green light to an Emergency Humanitarian Waiver. This waiver grants continued funding for the preservation of HIV programs at risk due to policy changes and the elimination of legal and other societal barriers to HIV treatment. However, other executive orders that closely followed stand to jeopardize existing infrastructure that supports HIV research and treatment.

Legislation Pertaining to Healthcare Professionals

Other types of legislation have been in place to govern healthcare provider practices surrounding HIV. At one time, U.S. legislation mandated that all medical

doctors and laboratories report newly-diagnosed cases of HIV to their community or state health departments. This became a requirement in the 1980s at the height of the HIV/AIDS epidemic to assist in managing its spread.

At the time of the reporting mandate, there were many discrepancies in how states were recording this information. This led to concerns regarding how names were stored and what measures were being taken to ensure the privacy of individuals with HIV. Code-based reporting is one method some states used, which replaced names altogether with coded identifiers. This was considered the most secure method since names were not stored at all. Another reporting form used was name-to-code-based, which involved recording a person's name, then converting it to code for storage once the data was used. This is seen as less secure. The last is name-based, which uses a person's name at all points during the reporting and storage process. This method fell under the most scrutiny, as confidentiality was a major concern.

While the aforementioned legislation has since been repealed, healthcare provider reporting is still strongly encouraged to assist with public health surveillance. Reporting protocols are now more standardized across the 50 states and 6 territories, which assists in responsibly managing all statistics.

Section 2 Personal Reflection

In what ways might HIV legislation impact the work a hospital-based occupational therapist does?

Section 2 Key Words

Public health surveillance - The process of gathering, analyzing, and interpreting health data to assist with making public health plans and decisions; this process is ongoing to ensure the most accuracy and systematic to allow for uniformity

Section 3: Occupational Therapy's Role in the Prevention and Clinical Management of HIV/AIDS

References: 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41

Due to the wide range of ways HIV and AIDS can impact someone's functional performance and quality-of-life, occupational therapists are well positioned to assist these individuals.

Patient Education Regarding HIV/AIDS Prevention

Prevention is a large component of an occupational therapist's role in HIV/AIDS. OTs can assist with the dissemination of knowledge to improve awareness and decrease stigma of these conditions. Occupational therapists can educate individuals about the following practices that assist with HIV prevention:

- Modifying one's sexual habits, including any of the following options:
 - Limiting the number of sexual partners
 - Avoiding sexual intercourse altogether
 - Choosing sexual practices that have a low association with HIV transmission (oral sex is one example along with any act that does not involve bodily fluid contact)

- If you do not have HIV but are at risk of contracting the virus (for example, if you are HIV negative, but have a partner who is HIV positive), taking pre-exposure prophylaxis (PrEP) as prescribed before sex
- Taking post-exposure prophylaxis (PEP) after a potential or confirmed HIV exposure
- Using condoms properly and consistently
- Getting regularly screened for STIs and other health conditions
- Encouraging your sexual partners to regularly go to the doctor's for STI screening and other preventive health exams
- Always using clean syringes, needles, drug-injecting equipment, and water when injecting any drugs, either legally or illegally
- Properly disposing of used needles in order to avoid accidental needle sticks or other contact with used needles
- Getting preventive treatment (e.g. vaccinations) and reactive treatment for any existing infections
- Understanding what can and cannot spread HIV
- Avoiding illnesses of any kind (especially those that indicate an acceleration of HIV or AIDS) and becoming educated on how to manage such illnesses if they do occur; these illnesses include:
 - Burkitt lymphoma
 - Histoplasmosis occurring outside the lungs

- Chronic intestinal isosporiasis, also known as cystoisosporiasis (especially when this lasts more than one month)
- Cytomegalovirus retinitis
- Extrapulmonary cryptococcosis
- Chronic intestinal cryptosporidiosis (especially when this lasts more than one month)
- Herpes simplex ulcers, bronchitis, pneumonitis, or esophagitis (especially when this lasts more than one month)
- Invasive cervical cancer
- Kaposi's sarcoma
- Encephalopathy with a root cause related directly to HIV
- Primary lymphoma of the brain
- Mycobacterium tuberculosis affecting any body system
- Recurrent pneumonia
- Progressive multifocal leukoencephalopathy
- Immunoblastic lymphoma
- Mycobacterium, mycobacterium kansasii, or mycobacterium avium complex occurring outside the lungs
- Candidiasis affecting the bronchi, trachea, esophagus, or lungs
- Pneumocystis jirovecii pneumonia
- HIV wasting syndrome

- Recurrent salmonella septicemia
- Toxoplasmosis of the brain
- Coccidioidomycosis occurring outside the lungs
- Cytomegalovirus disease outside of the liver, lymph nodes, or spleen
- Multiple or recurrent bacterial infections

Clinical Management of HIV/AIDS for OTs

There are many ways in which occupational therapy providers can help people with HIV and AIDS. These include:

- Physical agent modalities, complementary health approaches and integrative health (CHAIH), stress management, and energy conservation techniques to assist with managing symptoms of pain and fatigue
- Cognitive retraining, task adaptation, work simplification to assist with impairments in memory, attention, and problem-solving, which may occur later in the disease
- Adapted leisure to encourage participation in recreation such as sports, music, arts, and other activities
- Strength training to build endurance, strength, and range-of-motion, which assists with many occupational areas
- Assistive technology to maintain or improve independence in ADLs and IADLs

- Task simulation, role playing, location changes, and environmental modifications to assist with meaningful socialization, especially in public or unfamiliar places
- Accommodations such as additional breaks, screen readers, to improve ability to fulfill one's job duties
- Organization skills, planning, and the development of routines/habits/schedules to assist with adherence to all healthcare treatment regimens
- Lifestyle redesign principles, including modified exercises (if needed), sleep hygiene, and diet recommendations to assist with immune health and symptom management
- Education and counseling regarding symptoms (and their management), disease progression, managing comorbidities, activity limitations (if any), activity modifications, pertinent legislation based on their residence, and any other topics that apply
- Mental health approaches focused on managing secondary effects such as depression, anxiety, isolation, adjustment to the disease, self-esteem/self-image, quality-of-life, dignity, and maintaining the power of one's choice
- Sensory re-education and/or compensatory techniques to assist with the effects of peripheral neuropathy
- Advocacy within one's interprofessional healthcare team and beyond, based on someone's level of cognitive impairment, socioeconomic status, and social supports
- When HIV progresses to AIDS, treatment may shift to primary focuses such as seating and positioning, joint protection, spirituality, range-of-motion, endurance, and skin protection

- Identifying and addressing potential psychosocial concerns that may arise in individuals with HIV or AIDS, including low-self esteem, lack of social support, internalized homophobia, a history of abuse and trauma, difficulty adhering to traditional gender roles according to cultural norms, and the misuse of recreational drugs
- Assisting with HIV status disclosure to places of employment, significant others, and family members based on a patient's preference or contexts
- Adhering to universal precautions for blood and other bodily fluids when in medical settings such as hospitals and skilled nursing facilities

Research on OT and Related Treatment for HIV/AIDS

In an American Journal of Occupational Therapy (AJOT) study, Agner and Barile (2020) note that OTs have a particularly salient role in the treatment of HIV due to their capacity for managing complex psychological, medical, and social needs. Anger and Barile also suggest how community-based HIV treatment is one of the areas OTs can make the biggest difference due to the versatility of that setting and its focus on a patient's natural contexts.

A more dated AJOT study posits how the Model of Human Occupation (MOHO) is one of the most useful assessment tools for evaluating patients with HIV and AIDS since this population demonstrates a range of environmental, psychosocial, and physical needs that are sufficiently addressed by a person-centered therapy model. Another dated AJOT study looked more closely at how various levels of participation impacted the functioning of individuals with HIV and AIDS living in supportive housing. An intervention group took part in OT services aimed at improving productive participation while the control group received standard care. Results showed the intervention group demonstrated significantly higher levels of productive participation when measured 3, 6, and 9 months after the

program ended. Data also showed that members who received the intervention were at least two times as likely to be productively engaged during these same time intervals. This study shows particular support for use of the Model of Human Occupation and similar frameworks with those who have HIV and AIDS, as one of its researchers was Gary Kielhofner – the founder of MOHO.

While the majority of research surrounding HIV and AIDS involves adults, these conditions are also known to impact children. Munambah et al. (2020) found that children with HIV/AIDS have displayed lower playfulness abilities when compared to children without these conditions or other chronic disabilities. Since OTs have a large role in assisting children with developing play skills, this serves as evidence that OT can also benefit children with HIV/AIDS. An additional study led by Munambah et al. (2021) found that, in addition to health status, poverty levels also impacted the play abilities of children with HIV/AIDS. This study also came to the conclusion that children with HIV/AIDS who engaged in play more were perceived in a more positive light by others without the condition. This lends more support to OT's role in developing the play skills of children with these chronic conditions, which can help to address continued stigma surrounding HIV/AIDS.

HIV and AIDS can co-occur with a range of other health conditions, making it crucial for occupational therapists to offer well-rounded treatment for a complex set of health needs. Gill et al. (2024) tested the feasibility of virtual fall prevention-based OT to individuals with HIV and alcohol use disorder. This 10-week intervention was developed based on a needs assessment that showed a gap in care for such individuals with both conditions. The control group would receive written education about how to address falls and the impact of alcohol use on falls. The intervention group participated in home exercises, weekly group sessions provided via telehealth, and phone check-ins. Participants in the intervention group reported high satisfaction levels and strong participation for

the duration of the program. Early results showed this intervention has the potential to decrease fall risk for those with HIV/AIDS and alcohol use disorder as well as decrease the frequency of alcohol use altogether.

Sampaio et al. (2022) explored the efficacy of OT on Human T-lymphotropic virus 1 (HTLV-1)-associated myelopathy (HAM). HAM is similar to HIV, but does not have quite as widespread of an effect on the body's immune system. Either way, research on the benefits of OT on HAM can potentially be used in a clinical sense to inform treatment planning for this population. Results showed that, while rehabilitation is an important focus of OT treatment for this condition, intervention plans should also hone in on various levels of prevention to assist with goal achievement. This study also noted that individuals with asymptomatic HAM can benefit from OT to sidestep potential long-term ADL impairments.

Parmley et al. (2020) found that female sex workers with HIV living in South Africa experienced a range of occupational barriers, including but not limited to substance use, having their medications stolen, fear of wage loss directly related to impaired medication adherence, and work-related migration. This study also employed positive coping strategies interwoven within HIV treatment programs. Results not only showed improved health outcomes for female sex workers living with HIV, but also saw a positive association between these coping strategies, differentiated care efforts, and social cohesion.

Inceer et al. (2022) looked at risk factors that could impact treatment in middle-aged and older adults living with HIV. This study showed that tobacco, alcohol, and cannabis use along with certain comorbidities – namely kidney disease, liver disease, osteoporosis, cancer, hypothyroidism, lung disease, and peripheral vascular disease – have the potential to increase frailty in those with HIV. The most notable comorbidity associated with HIV frailty is arthritis. However, results also found that some degree of frailty was attributed to HIV itself. Researchers

also discovered emotional and cognitive frailty were more prevalent in those with HIV than physical frailty was. This emphasizes the importance of comprehensive, integrated care for those with HIV.

As you can see, there is a range of research in support of the work OTs can do with individuals who have HIV and AIDS. However, the occupational therapy field can always benefit from additional research to contribute to the credibility of the work we do. In particular, there is not always a lot of evidence supporting niche areas, such as HIV and occupational performance in older adults, the co-occurrence of HIV and mental health concerns, the impact of OT treatment on patients with HIV and diagnosable mental health conditions, and more. These offer many opportunities for occupational therapists to expand our profession's evidence base.

Section 3 Personal Reflection

What interventions (including assistive technology and therapy techniques) might be helpful for a 41-year-old female with HIV who is experiencing neuropathy, chronic fatigue, and feelings of helplessness?

Section 3 Key Words

Peripheral neuropathy - A neurological condition that impacts the nerves that branch out from the spinal cord and brain; these are called peripheral nerves and carry signals from the brain and spinal cord to nearly all parts of the body; symptoms of peripheral neuropathy include sensitivity to pain, numbness, tingling, slowed reflexes, impaired balance, and hypersensitivity in various parts of the body

Section 4: Case Study #1

A 55-year-old female has just been diagnosed with HIV. Her doctors suspect the patient obtained this HIV status after sharing needles, as she recently relapsed on heroin and has a history of unsafe drug-related practices. The patient was previously 3 years clean and her relapse occurred after she lost her job and she got evicted from her apartment. She is now living on the streets and reports having no concrete plans to get clean again. However, she has intermittently verbalized being “unsure of how long I can keep living like this”. She has also been diagnosed with major depressive disorder, panic disorder, and social anxiety. During her time in a woman’s shelter, she begins receiving community-based OT per a referral from her primary care physician.

1. What intervention categories are likely to be the most effective for this patient?
2. What additional therapeutic approaches may be best suited for the early stages of treatment?
3. Is it within the scope of practice for a community-based OT to address the physical symptoms of this patient’s HIV and drug use disorder?

Section 5: Case Study #1 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What intervention categories are likely to be the most effective for this patient?

Since this patient was only recently diagnosed, it is important to include educational goals in her treatment plan. In particular, education should include what symptoms to expect as well as how to minimize the spread of HIV to others. The therapist may want to offer various forms of education to enhance carryover. The patient reports having no concrete plans of getting clean, so therapists (and other care professionals) should also provide harm reduction for the safety of her and others she associates with. Building rapport will be another major aspect of treatment in the early stages to assist with compliance, as this patient's drug use may lead her to present with low motivation, difficulty engaging, and possibly even agitation or hostility.

2. What additional therapeutic approaches may be best suited for the early stages of treatment?

The therapist should take this patient's co-occurring drug use into consideration during treatment planning and when selecting treatment approaches. The patient has expressed some sentiments of wanting to get clean, so the therapist may want to use the Transtheoretical Model (Stages of Change Model) to assist when she deems the timing is right. Based on the results of this patient's evaluation, the therapist may also want to address independent living skills. This will assist with supportive housing efforts that other members of the patient's treatment team may be planning for. Since this patient has several co-occurring mental health conditions, the therapist should use aspects of MOHO, Cognitive Behavioral Therapy (CBT), and Interpersonal Therapy (IPT) to effectively address her symptoms of depression and anxiety.

3. Is it within the scope of practice for a community-based OT to address the physical symptoms of this patient's HIV and drug use disorder?

Yes. There are no setting- or practice-based limitations that prevent therapists from using only part of their expertise with patients. Therefore, if the therapist is educated in the proper techniques, interventions, assistive technology, etc. to assist with this patient's physical symptoms, then she can do so.



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